February 21, 2008

Jon Neiderbach
Issuing Officer
Iowa Department of Human Services
Division of Financial, Health and Work Supports
1305 E. Walnut, 5th Floor
Des Moines, Iowa 50319-0114

Dear Mr. Neiderbach:

Thank you for the opportunity to provide additional information to clarify the matters addressed in your letter dated March 14, 2008. Pursuant to the terms of the RFP, we are submitting this information as part of our Best and Final Offer.

I. Eligibility and enrollment experience with SCHIP

HMS has been involved in the eligibility determination process for ***hawk-i***, the Pennsylvania CHIP, and the New Jersey CHIP since the beginning of 2007. Specifically, HMS has keyed or batch loaded applicant information into our Web-based **COB***Match* product, searched for other insurance, verified the insurance information with the carrier, and returned to the state any validated third-party coverage. West Virginia also just recently contracted with HMS for this same service. Not only is this process important to ensure that critical funds be spent on the population in most need, but as a matter of program compliance, HMS ensures that enrollment practices meet Federal guidelines.

As indicated by the table below, HMS has also assisted another 20 SCHIPs to identify children with other coverage as part of our Medicaid insurance identification process. The CHIP populations are included with the Medicaid eligibility and Medicaid paid claims file that we receive, and HMS has performed third party liability identification and recovery services for these populations to ensure the correct disbursement of state and federal dollars.

State	Name of SCHIP	SCHIP Enrollment (6/2006)*	Contract for Medicaid Insurance Adds and/or SCHIP?	Does HMS locate other insurance for CHIP kids or applicants?	Does HMS pursue CHIP Recoveries thru XIX Contract?	SCHIP included in the Medicaid Eligibility tape feed?
Alaska	Denali KidCare	9,582	XIX Adds	Yes	Yes	Yes
Arizona	KidsCare	59,250	XIX Adds	Yes	Yes	Yes
Arkansas	ARKids B	67,170	XIX Adds	Yes*	No	Yes
Delaware	Delaware Healthy Children Program (DHCP)	4,844	Neither	No	Yes	Yes
Florida	Florida KidCare Program	193,839	XIX Adds	Yes*	No	Yes
Georgia	PeachCare for Kids	257,212	Both	No	Yes	Yes
Idaho	Idaho Children's Health Insurance Plan	14,287	XIX Adds	Yes	Yes	Yes

State	Name of SCHIP	SCHIP Enrollment (6/2006)*	Contract for Medicaid Insurance Adds and/or SCHIP?	Does HMS locate other insurance for CHIP kids or applicants?	Does HMS pursue CHIP Recoveries thru XIX Contract?	SCHIP included in the Medicaid Eligibility tape feed?
Indiana	Hoosier Healthwise	68,787	Neither	No	Yes	Yes
Iowa	*hawk-i* (Healthy and Well Kids of Iowa)	36,285	SCHIP	Yes	No	No
Kansas	HealthWave	37,631	Neither	No	Yes	Yes
Kentucky	Kentucky CHIP (KCHIP)	50,225	XIX Adds	Yes	No	Yes
Maryland	Maryland Children's Health Program	101,582	XIX Adds	No	Yes	Yes
Massachusetts	MassHealth	75,019	XIX Adds	Yes	Yes	Yes
Missouri	Managed Care Plus (MC+) For Kids Program	61,097	Neither	No	Yes	Yes
Nevada	Nevada Check Up	27,040	XIX Adds	Yes	Yes	Yes
New Jersey	New Jersey FamilyCare	127,525	XIX Adds	Yes	No	No
North Carolina	North Carolina CHIP Program	144,148	Neither	No	No	Yes
Oklahoma	SoonerCare	58,731	Neither	No	Yes	Yes
Pennsylvania	Pennsylvania CHIP	143,501	SCHIP	Yes	No	No
South Carolina	Partners for Healthy Children	40,181	XIX Adds	Yes	Yes	Yes
Texas	TexCare Partnership	293,342	XIX Adds	No	Yes	Yes
Virginia	Family Access to Medical Insurance Security Plan (FAMIS)	78,745	Neither	No	Yes	Yes
West Virginia	West Virginia (WV) CHIP	24,835	Both	Yes	Yes	No

** Source: Kaiser State Health Facts*

II. Eligibility and Enrollment Experience with Medicaid

HMS has demonstrated experience with Medicaid eligibility and enrollment projects, as documented below.

A. Medicaid Expansion Experience

HMS has supported two Medicaid expansion projects performing premium processing. In West Virginia, HMS manages the premium buy-in expansion program, called MWin which has allowed 400 disabled individuals to buy into the program. HMS receives, processes, and posts all checks associated with this program within program-defined timeframes.

Beginning in 2005, HMS began receiving all IowaCare premiums and posting them to the Iowa MIPS system. In SFY 2006, HMS processed and posted over 40,000 insurance premiums and assisted DHS in setting up a lockbox and utilizing scanline technology to automate the posting process. This efficient method of posting, which was suggested by HMS, has resulted in significant operational savings for the Department. HMS continues to manually post payments received without coupons and hardship waivers for the Department.

B. HIPP Program Experience

Health Insurance Premium Payment programs are Medicaid programs designed to offset medical costs to the Medicaid. In that regard, HMS has direct experience with Medicaid eligibility. As we discussed in the ***hawk-i*** oral presentation on March 11, HIPP responsibilities directly relate to the Iowa ***hawk-i*** TPA service requirements in the following way.

1. *Application processing* - Both programs require completion of detailed applications to join the program.
2. *Eligibility Determination* - Both programs have set formulas to determine eligibility in the state plan. Eligibility for HIPP is based on a cost-effective formula as described in the state plan. This complex formula is based on the cost of health insurance premiums, out-of-pocket cost (copayments, deductibles, coinsurance) for the recipient, benefit levels of the plan, and past medical costs of the recipient. All information must be verified with documentation requested from the employer, the insurance carrier, and/or the MMIS. By contrast, eligibility determination for ***hawk-i*** is based primarily on the word of the applicant and the information on the application. Initially, the last thirty days of pay stubs are all that's required to verify income for ***hawk-i*** eligibility.
3. *Verification of information from pay stubs* - The supporting documentation most commonly used by both HIPP and ***hawk-i*** are employee pay stubs. For HIPP, the amount paid for premiums is recorded as well as the frequency, whereas for ***hawk-i*** the gross payment from the employer is recorded along with the frequency. Validation of countable income for the ***hawk-i*** program is performed only during the initial verification process and annually thereafter during renewal. This verification process must occur monthly for HIPP, so copies of all pay stubs must be sent in each month.
4. *Verification of other insurance* - Both HIPP and ***hawk-i*** require verification of other known coverage with the insurance carrier before enrollment can proceed. HMS verifies coverage with each insurer and records the effective date for the HIPP program. As the TPA for the ***hawk-i*** program, HMS would require a termination letter from the insurance carrier to show the insurance was dropped.
5. *Correspondence Generated* - Both HIPP and ***hawk-i*** generate letters to program applicants and/or members for the following reasons:
    i. Incomplete applications, additional information needed
    ii. Enrollment notices
    iii. Ineligible notices
    iv. Late notices
    v. Cancellation notice
    vi. Right to appeal decision
6. *Case-Driven Enrollment* - more than one program may cover any given enrollee in the household; therefore, both case and individual unique identifiers are used for tracking purposes.
7. *Referrals for both programs usually come from caseworkers (Income Maintenance Workers)* - Caseworkers are the primary source of referrals for both programs; often, referrals result when the potential enrollee has applied for the Medicaid program. For HIPP, the referral is made when access to other insurance is known, whereas for ***hawk-i***, the referral occurs when the applicant exceeds federal poverty level guideline for Medicaid.
8. *Customer Service Interaction* - Both programs have long-term interactions with enrollees and their families. Both HIPP and ***hawk-i*** members may become ineligible for the program and resume Medicaid benefits.

9. *Premium Management* - Both programs require monthly premium management by the third party administrator. For HIPP, the TPA ensures that the enrollee is paid the monthly premium after receiving proof of payment from the member. For ***hawk-i***, the TPA generates premium coupon and collects the monthly premium. For both programs:
   i. non-response results in cancellation from the program
   ii. a grace period must be observed by the TPA
   iii. enrollees who have been cancelled can be reinstated, but with some loss of plan coverage
10. *Annual renewals* - Both programs re-evaluate coverage on an annual basis. For HIPP this entails gathering all claims information in the past year to determine medical costs, contacting the employer for new premium amounts and service levels, and contacting the insurance companies for out-of-pocket costs and levels of coverage included under the policy; this information must be tallied to ensure ongoing cost-effectiveness for the state. For the ***hawk-i*** program, a renewal application is sent to the household and recent pay stubs are collected. This information is keyed into the system to determine if ***hawk-i*** eligibility should continue.

The table below was submitted in our proposal and outlines HMS's eligibility and enrollment experience, including our administration of a very large HIPP program that is similar in size to the ***hawk-i***. HMS has been administering the Massachusetts Family Assistance Program for the past eight years and performs all of the functions as describe above. In many ways, the administration of a HIPP program is equally as complex as administering an SCHIP, especially in terms of eligibility determination and the monthly verification process required to validate insurance premium deduction from all employee pay stubs.

Our experiences helping state Medicaid agencies administer projects entailing case enrollment, premium management, and eligibility determination will enhance our success for Iowa's hawk-i program.

State/Program	Start Date	Contract Description	Services relevant to hawk-i
Massachusetts Family Assistance Program - Enrollment Services	1998	This program identifies families who meet eligibility requirements and ensures enrollment to their employer-sponsored health insurance plan. Through the efforts of HMS, the Family Assistance program has assisted over 16,500 low-income MA residents since 2000.	▪ Application processing ▪ Eligibility Determination ▪ Customer Service ▪ Reporting
Massachusetts Family Assistance Program - HIPP	2002	HMS began assisting MassHealth with the management of the MassHealth Standard/CommonHealth Premium Assistance Program (MSCPA), formerly know as the HIPP Program. MassHealth members are required to obtain group-sponsored health insurance, if available. HMS has enrolled more then 15,000 members into group sponsored health insurance through the MSCPA Program.	▪ Application processing ▪ Eligibility Determination ▪ Customer Service ▪ Premium Management ▪ Reporting
West Virginia HIPP	1996	HMS performs eligibility determination by validating that third party insurance meets the minimum program rule requirements and is cost effective. HMS also supports all premium management functions and manages the premium buy-in expansion program, which has allowed 400 disabled individuals to buy themselves into the program.	▪ Application processing ▪ Eligibility Determination ▪ Customer Service ▪ Premium Management ▪ Reporting

State/Program	Start Date	Contract Description	Services relevant to hawk-i
Georgia Department of Community Health - HIPP	1996	HMS performs marketing and outreach to local welfare offices, as well as application development and processing services. HMS also validates the insurance, measures the cost-effectiveness for buying Medicaid recipients into the program, and performs all financial and statistical reporting.	▪ Application processing ▪ Eligibility Determination ▪ Customer Service ▪ Premium Management ▪ Reporting
South Carolina Medicaid Program - HIPP	2007	HMS provides a web-based technology solution which determines the cost-effectiveness of HIPP enrollment. HMS trained the state staff to utilize the system, which provides for optimal premium management and financial reporting and is accessible to state employees and members. The HMS team is also providing our verification case management system to support the insurance validation for the SC SCHIP beneficiaries included as part of the Medicaid expansion program.	▪ Application processing ▪ Eligibility Determination ▪ Customer Service ▪ Premium Management ▪ Reporting
New Jersey – Dept of Human Services – FamilyCare (including Medicaid and SCHIP)	2004	HMS provides comprehensive cost avoidance, TPL identification, verification, and program eligibility qualification services (TPL disqualifies participation in certain New Jersey SCHIP and Medicaid programs) as well as post payment recovery of Medicaid Managed Care encounter claims and fee-for-service claims. HMS operates a call center that provides daily support to NJ beneficiaries, responding to a wide variety of inquiries.	▪ Customer Service ▪ Reporting
Florida - Agency for Health Care Administration – Medicaid Opt Out Program	2006	Similar to HIPP, Opt Out is a new Medicaid Reform program where Medicaid beneficiaries are provided the opportunity to "opt out" of Medicaid into employer-sponsored health insurance plans. HMS helps to enroll recipients in the Opt Out program when they qualify, and manages the premium reimbursement efforts on behalf of AHCA.	▪ Eligibility Determination ▪ Customer Service ▪ Premium Management ▪ Reporting

III. Experience of key personnel on similar projects

All four of our key staff have over ten years of experience supporting similar projects in the capacities assigned to them for the ***hawk-i*** program. Combines, these four individuals alone have over 100 years of healthcare experience.

A. John Davis, Project Manager

John Davis, our proposed Project Manager, worked for a small health plan determining eligibility, managing customer service staff and activities and overseeing mailroom activities. He served in this managerial role for eight years. John then moved into state government role as the account manager of Revenue Collections for the Iowa Medicaid Enterprise.

- *Iowa Medicaid Enterprise, Account Manager, 2006-2008*
  - Supervised the review of ***hawk-i*** applications for other insurance and performed Third Party Liability (TPL) verifications for applicants and enrollees of the Iowa ***hawk-i*** program in 2007
  - Ensured that we met or exceeded all requirements of the ***hawk-i*** contract with HMS, which includes returning discovered TPL within 3 days to the ***hawk-i*** staff in 2007.
  - Application processing - Supplemental Insurance Questionnaires (SIQs), which are similar to ***hawk-i*** applications. SIQs must be verified and entered into the MMIS within 10 business days of receipt. To ensure we meet the timeframe, we design our work queues with timers, which prompt staff for timely follow-up.
  - Eligibility Determination - Complete eligibility determination for other insurance by using HMS ECARE system, which contains all of the criteria needed to determine if the other

insurance is valid. Our staff verifies insurance coverage by contacting insurance carriers and verifying the accuracy of the existing information. The staff makes the final determination as to whether the insurance information should be used for cost avoidance purposes.

- Document Imaging and Workflow-All scanned images are routed based on form type to certain work queues for indexing and key worded. Key wording allows us to call up all imaged documents related to a case or recipient. These are the same workflow steps needed for applications, renewals, and other documents that are received by ***hawk-i***.
- Premium Collection- Enter all IowaCare premiums into the system, although we have recently automated most of this. We worked closely with DHS and Wells Fargo to establish a scan line on the premium coupons that allows the bank to create a daily file feed of payment that goes directly into the MIPS system. We still manually key all hardship waivers and checks with missing coupons. We also send follow-up correspondence to members for unsigned checks, insufficient funds, wrong Payee, postdated or undated check, no dollar amount listed
- Surveys-TPL and trauma lead letters are insurance surveys that are sent monthly to Medicaid members. We must act on all responses within the required timeframes. HMS processes 2,500 surveys per month.
- Appeals-Prepared, attended and defended the Iowa Department of Human Services at all pre-hearings and hearings regarding provider credit balance appeals since 2006.

- *Customer Service and Claims Unit, Department Manager, Select Benefit Administrators, 1998-2006*
  - Performed COBRA eligibility determination and group eligibility loads. Production, documentation, response time requirements were embedded in this process.
  - Administered a customer service unit. This was a blended unit where all claims processors responded to member and provider calls. Production and response timeframes were embedded in this process.
  - Oversaw mailroom activities including opening, date stamping, and delivering daily mail and document preparation for scanning. Created electronic eligibility billing and reporting processes.
  - Created customer survey cards that were sent to the members for feedback on customer satisfaction.
  - Participated in a SAS-70 audit of procedures and systems. Created and maintained audits and accuracies.
  - Created detailed monthly reporting for claims, telephones and audit accuracy.

B. Pam Moores-Program Director

Pam Moores, our Iowa Program Director Manager, recently began working with HMS in 2008, but was a satisfied customer of HMS during her many years with the State of Colorado. As the current Program Director, Pam oversees HMS's ***hawk-i*** **COB***Match* contract with DHS. As TPL Director in the State of Colorado for seven years, she worked directly with the SCHIP from the program's inception. She has worked on projects similar to the ***hawk-i*** program as demonstrate by the following list:

- *TPL Director, State of Colorado, 1994-2006*
  - Implementation of SCHIP (called CHP+) in Colorado, including processes associated with integrating the following systems: Medicaid MMIS, eligibility, and CHP+ eligibility (then with PSI).
  - Investigated the cost effectiveness of premium payment for SCHIP-eligible children in Colorado
  - Reviewed RFP to secure new CHP+ eligibility vendor in Colorado

- Integrated CHP+ eligibility into the MMIS system for capitated payments to health plans as the IT Contracts and Monitoring manager; became the key link to CMS to obtain approval for work plan to implement these changes into the MMIS.
- Formulated requirements definition for the new Colorado Benefits Management System (CBMS) and led the team outreaching to county staff, CHP+ staff and Medicaid offices to examine Business Process Reengineering and gather requirements to program into this new rules-based system that housed all human services/Medicaid programs.
- CBMS implementation, which involved extensive MMIS testing to assure accurate data transmission occurred. Addressed eligibility issues that came out of the implementation of CBMS in 2004, resolving claims payment issues with providers and clients.

- Worked with the local Health Department, with prenatal clinics that assisted with eligibility applications for Baby Care/Kids Care. The program rules for eligibility are similar to the ***hawk-i*** program, and the same application is now used by the state of Colorado.
  - Ensured the correct information was collected prior to sending applications to the county for data entry and final determination.
  - Each applicant found presumptively eligible was provided a temporary card, which enabled the applicant to begin prenatal care same day.

- Worked as an AFDC caseworker for one year in Chaffee County in Colorado, which involved eligibility re-determinations. Participated in child welfare work in the county.

- Worked as a nurse consultant in Denver County Social Services - facilitating training of AFDC mothers to go to work and transition off of welfare. Knowledge of program eligibility rules was required to inform the women as to what benefits they would still be eligible for once they had income as a Certified Nursing Assistants.

C. Joe Drapalik-Proposed Systems Manager

Joe Drapalik, our proposed system manager, has been working with HMS and its subsidiaries for years. He has worked on several projects requiring the skillsets needed for system enhancement oversight and tracking, along with applying a thorough understanding of the healthcare industry and government-related programs.

- Senior Developer and Designer for an HMS subsidiary that wrote and maintained software for commercial health insurance companies for five years. He wrote and maintained software from 1991 to 1995. Specifically, he worked on the Group Administration, billing, and eligibility system for BC/BS of NCA.

- Lead Technical Designer for HMS for several applications, such as Phoenix and **COB***Manager*. Designed HMS's proprietary claim database in 2003 and ensured its integration with other core HMS applications, such as our Provider Portal and Maestro, a case management system that is the base of **KID***Connect*.

- Chairs HMS's Framework Review Board whose mission is to ensure that all HMS applications are built using standardized components and programming techniques thereby ensuring easy reusability and integration. Added benefits include a decreased learning curve when bringing on new programmers and transferring existing developers between teams.

D. Bob Britton-Proposed Implementation Manager

Bob Britton is highly qualified to serve as both the Implementation Manager and a key technical advisor on this engagement. We have highlighted below a list of Mr. Britton's key SCHIP related project accomplishments.

While at MAXIMUS he served as a Division President and Senior Vice President and Chief Operations Officer for the SCHIP with full financial responsibility. In this role, the SCHIP Project Team reported directly to him for the Western Region. Mr. Britton's accomplishments included:

- The successful implementation of:
  - a new SCHIP Enrollment and Disenrollment System
  - a new SCHIP Operations Call Center
  - SCHIP Operational Policies and Procedures
  - SCHIP Training Program
  - a Premium Billing and Accounting System
  - a new Imaging System
  - Lock Box Operation
  - a new Telephone System
  - ISO 9000:2000 Certification

- Served on the Audit Committee for the SCHIP in California. This committee was made up of both State and MAXIMUS Corporate/Management Staff. In this role, he participated in all internal and external SCHIP audit activities including SAS 70 and OMB 133 audits performed by external auditors

While at MAXIMUS, Mr. Britton served as a key member of the Project Management Office responsible for implementing the Texas Integrated Eligibly program. His duties included:

- Documenting the many issues related to the implementation of a new imaging system used for work flow processing of select application types and reporting to the PMO recommended actions
- Documenting the issues with the Quality Assurance Program and implementing changes to systems, personnel, processes and procedures.

In addition to the SCHIP experience, he served as the Division President, Senior Vice President and Chief Operations Officer for the Enrollment Broker Project in California. This project enrolled Medicaid Recipients into Managed Care Programs in California. Mr. Britton's accomplishments include:

- Development of detailed policies and procedures that enabled the project to be the first project in MAXIMUS history to obtain ISO 9000:2000 Certification.
- Implementation of the first comprehensive contract compliance monitoring process designed to measure and report detailed project compliance.
- Implementation of the first comprehensive risk analysis ever undertaken by a project in MAXIMUS resulting in the design and implementation of procedures to mitigate risks inherent in Enrollment Broker contracted services.
- Implementation of new Call Center Technology enabling higher quality of service for the state and the Medicaid beneficiary.
- Enrollment of 2M plus Medicaid recipients into Managed Care Programs in California with no complications
- Development of Enrollment Broker Materials in more than 10 languages
- Development of New Imaging System

- Implementation of cost savings for the State of California exceeding several million dollars.

As documented in our proposal and stated at our oral presentations, Mr. Britton's role with the project will not end at the implementation date. He will continue to be engaged with the project as a consultant to Pam Moores and John Davis. Mr. Britton's SCHIP operations expertise will be utilized heavily during operations as he works with Mrs. Moores and Mr. Davis to ensure that we are meeting or exceeding the Department's expectations. Some of Mr. Britton's post-implementation responsibilities will include:

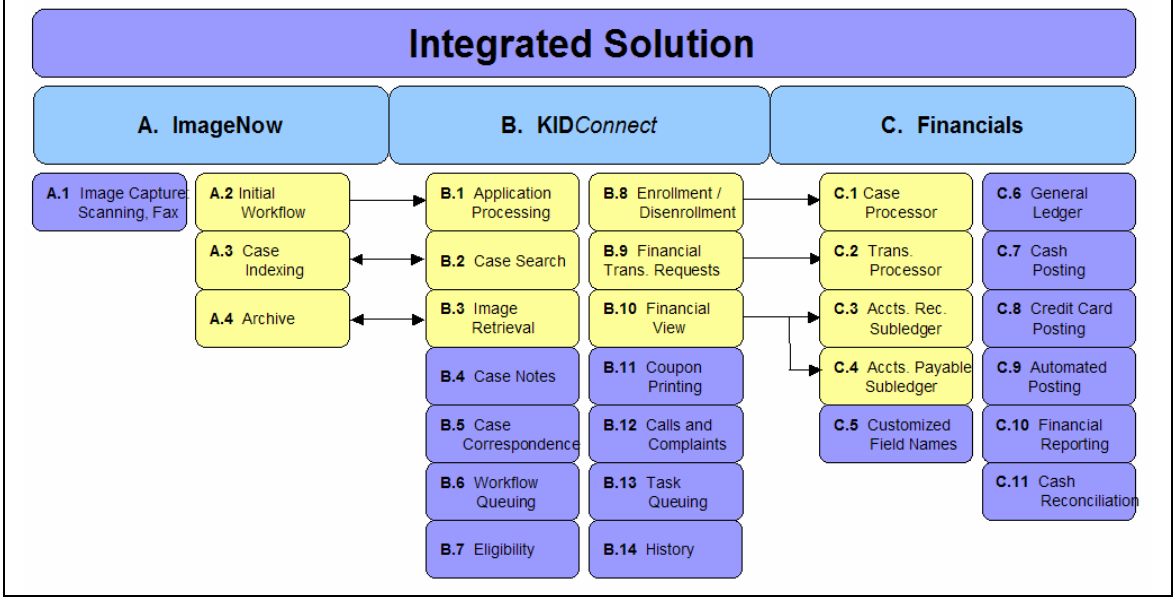
- Daily and monthly reviews of key production reports
- Conducting root cause analysis on reported problems and identifying and executing necessary corrective actions
- Identifying and implementing process improvements
- Review of quality assurance findings and recommendations for corrective actions

IV. Further explain the integration of system components and staff interaction with the system in a unified manner for the eligibility determination and case management processes.

The RFP calls for an integrated system. HMS has **KID***Connect*, a fully integrated system to be used for ***hawk-i*** that also interfaces with two other well-known applications: ImageNow, HMS's corporate choice as a document imaging and workflow solution, and PeopleSoft financials, for its corporate ledger. The three systems interface to form a fully integrated solution to capture, track, retrieve, process and store all data needed and required processes for ***hawk-i***.

The integrated system is designed to automate as many functions as possible in order to ensure timely processing of applications, eligibility determinations, premium coupons, notices, etc. At the same time, the system is also extremely user-friendly in order to promote ease of use and the automatic assignment of next steps within a very complex process. Yet where critical points occur in the decision-making process, such as in a final eligibility determination or refund, human intervention is required to complete the transaction as a way of forcing a final quality review.

HMS offers a fully integrated service solution for hawk-i administrative solutions.



In the above diagram, the yellow boxes indicate the integration point of the system. To respond to ***hawk-i***'s concerns of application processing and case management and how the user would interact with the integrated system, we focus below on three areas: application processing, grace period processing, and how would a customer service representative interact with the system during a typical customer service call for both a new applicant and an existing enrollee. We have responded in a text format, as well as a more detailed Who-Does What-When format.

A. Application Processing

Most applications will be accepted into HMS's system via Web or via scanned or faxed images. In step **A.3** our mail room staff completes the indexing so that the image is linked permanently to an application. In step **A.5** our Enrollment Coordinators complete the keying of the application. The system then queues completed applications to our enrollment coordination staff to evaluate the application and the supporting documentation. Step **A.7** outlines the eligibility coordinators interaction with the system to perform the eligibility determination; this is a combination of system rules, which guard against human error, but which also needs human interaction to approve the determination. Steps **A.8** through **A.15** outline the system-generated tasks driven by the new enrollment. In step **A.16**, the mailroom staff can batch print all applicant correspondence and premium coupons generated by **KID***Connect* before the close of business each day to ensure timely mailing.

Step	Who	Does what	When	Application
A. Application Processing				
A.1.a	Any applicant	Keys application information into HMS's Web site. The system allows the applicant to fill out the application online. System prompts for all required fields to be completed before system acceptance.	Web application	Web application
A.1.b	Any applicant	May fax an application to HMS's dedicated 800-number. The system accepts all applications faxed to HMS's dedicated 800-number, and places application images into our ImageNow input queue.	Faxed	ImageNow Fax Server
A.1.c	Mail room staff, receptionist	HMS will accept all paper applications. These applications will be scanned, and placed directly into our ImageNow input queue.	Mailed or walked-in	Scanner connected to HMS's LAN
A.1.d	Any applicant or DHS employee	Any office may fax the application to HMS's dedicated ***hawk-i*** fax number. As per 1.b, all faxed imaged are queued for indexing.	Other state office	ImageNow Fax Server
A.2	System	Application form is recognized by the ImageNow system and sent to an application prescreening queue to be worked.	Continuous, as images are received	ImageNow rules
A.3	Mailroom staff, Receptionist	Key wording of application head of household name. Date received is already added to the image information screen. ImageNow generates a unique application ID. Supporting documentation (pay stubs, etc.) are indexed with the same head of household name, the same application ID and assigned the appropriate document type.	Continuous, as the images are received	Image Now
A.4	System	The system automatically archives the images and their associated indexes, so that they are easily accessible from KID*Connect*	As A.3 is completed for each application	ImageNow
A.5	Enrollment Coordinators	Application Processing. All information from the scanned ***hawk-i*** applications and supporting documentations are keyed into the application form tab within KID*Connect*, which mimics the paper ***hawk-i*** application. Applications with all required data and supporting documentation are assigned	Continuous	KID*Connect*

Step	Who	Does what	When	Application
		to a task of eligibility determination. Applications needing additional information are sent to a follow-up queue. Customer Service Reps are assigned applications needing follow-up via workflow queues within KID*Connect*.		
A.6	System	Image Retrieval	As each application is being viewed in A.5	KID*Connect*
A.7	Enrollment Coordinators	Eligibility Determination. Enrollment coordinators are assigned eligibility determinations for complete applications with the needed supporting documentation. A future enhancement is to enable the Enrollment Coordinator to check for other insurance and Medicaid eligibility from within KID*Connect*, but until the process was integrated, this is accomplished by using the MMIS and COB*Match* to search for other insurance leads. The Enrollment Coordinator enters their findings into the appropriate fields for Medicaid coverage and other insurance. The system processes the key fields from the application (age, % FPL based on number in household and countable income, IA residency, state employee dependent status, etc.) The system instantaneously proposes an eligible, not-eligible, refer to Medicaid, or proposes a pending status needing more information at this point for each dependent for whom coverage was requested. The Enrollment Coordinator then reviews all eligibility information and either approves or overrides the system determination for each dependent. If overridden the system prompts the enrollment coordinator to document the reason and notification of the override is sent to the Customer Service Supervisor. After searching for prior eligibility, each new household with eligible dependents is assigned a unique case number. Each new eligible dependent is assigned a unique identification number. All eligible children are sent to an enrollment queue for further processing.	Continuous	KID*Connect*
A.8	System	Enrollment / Disenrollment. Once an application is approved a New Case task is created to inform the Financial Case Processor to create new enrollee and corresponding ledger accounts.	After A.7	KID*Connect*
A.9	System	Non-enrollment Notification	After A.7	
A.10	System	Financial Transaction Requests	After A.8	KID*Connect*
A.11	System	Case Processor	Continuously monitoring for A.8	PeopleSoft
A.12	System	Transaction Processor	Continuously monitoring for A.9	PeopleSoft
A.13	System	Coupon Printing	After A.11	KID*Connect*
A.14	System	Task Queuing	After A.11	KID*Connect*
A.15	System	History	After A.11	KID*Connect*
Mail room support				
A.16	Mail support clerk	Mail room support for: - Ineligible letters	Daily	Scanner/Printer

Step	Who	Does what	When	Application
		- Notice of Enrollment - Premium Coupon mailing		

B. Cash Posting and Grace Period Processing

Section 3.C describes HMS's proposed cash posting and grace period processing workflow. In the following table we have integrated these functions with both who is doing the function, as well as what HMS application is being used to support the function. Please note that while cash posting is carried out automatically for those payments that arrive with the proper remittance coupon at the lockbox (Step **B.1.a**), and to a lesser degree manually by our staff (Step **B.1.b**), the grace period processing is performed by HMS's **KID***Connect* system which carries out ***hawk-i*** policy. Step **B.19** indicates the correspondence that is autogenerated by the system and is batch printed and mailed out by the mailroom staff before the close of each business day.

Step	Who	Does what	When	Application
B. Grace Period Processing				
B.1.a	Cash Posting Clerk at bank	Scans bar-coded premium coupon sent with check or money orders. Creates electronic daily receipt file sent from bank, which is uploaded to PeopleSoft. Payment to the earliest ledger record created	Daily. All posted before month end	PeopleSoft
B.1.b	Receptionist or Enrollment Coordinator	Receives copies of checks for payments received at lockbox without premium coupons. Posts payment to the earliest ledger record created	Daily. All posted before month end	PeopleSoft
Payment Late				
B.2	System	Create Reminder Notification PDF	Day 10 of month	KID*Connect*
B.3	System	Store PDF	After B.2	KID*Connect*
B.4	System	Print PDF	After B.3	KID*Connect*
B.5	System	Store as a completed Event	After B.4	KID*Connect*
Payment Late & No Grace Periods Left				
B.6	System	Create Disenrollment Notification PDF	Day 20 of month	KID*Connect*
B.7	System	Store PDF	After B.6	KID*Connect*
B.8	System	Print PDF	After B.7	KID*Connect*
B.9	System	Store as a completed Event	After B.8	KID*Connect*
B.10	System	Create Disenrollment Journal Entries to close out A/R	After B.9	KID*Connect*
Payment by Day 31 & within Grace Period				
B.11	Cash posting clerk at bank	Scans bar coded premium coupon sent with check or money orders. Creates electronic daily receipt file sent from bank, which is uploaded to PeopleSoft. Payment to the earliest ledger record created	Daily	PeopleSoft
B.12	System	Create Reinstatement Notice PDF	Daily, after B.11, within Grace Period	KID*Connect*
B.13	System	Store PDF	After B.12	KID*Connect*
B.14	System	Print PDF	After B.13	KID*Connect*
B.15	System	Store as a completed Event	After B.14	KID*Connect*
B.16	System	Create Reinstatement Journal Entries	After B.15	KID*Connect*
Late Payment & No Grace Periods Left				
B.17	Cash posting clerk at bank	Scans bar coded premium coupon sent with check or money orders. Creates electronic daily receipt	Daily	PeopleSoft

Step	Who	Does what	When	Application
		file sent from bank, which is uploaded to PeopleSoft. Payment to the earliest ledger record created		
B.18	System	Refund is scheduled	Daily, after B.17, post grace period	PeopleSoft
Mail room support				
B.19	Mail support clerk	Mail room prints and prepares the following batched correspondence generate by Kid Connect: - Reminder Notifications (monthly) - Disenrollment Notifications (monthly) - Reinstatements (daily) - Refunds (daily)	Daily	-

C. Typical Customer Service Interaction with Applicant

When a new applicant contacts the ***hawk-i*** program regarding the status of his/her application, the customer service coordinator will call up the application using the head of household or other adult listed on the case, as in step **C.2.** In steps **C.4.a** and **C.4.b**, the Customer Service Coordinator can quickly change screens within the **KID***Connect* application to access premium information and health plan information for the applicant, as well as to input information. In step **C.6**, the system prompts the CSC to generate correspondence to confirm the health plan selection indicated. Step **C.7** is the system-generated final enrollment step which adds the new applicant as an enrollee on the 834. Step **C.8** once again indicates the printing and mailing that may result after a typical customer service interaction with an applicant.

Step	Who	Does what	When	Application
Typical Customer Service Interaction-applicant and enrollee inquiries				
Applicant Inquiry				
C.1	*hawk-i* applicant mother	Calls the *hawk-i* program to check the status of her child's application	During the first 10 days after submitting the application	-
C.2	Customer Service Coordinator	Answers the call and asks for the head of household name from the application. The CSC enters the KID*Connect* Application Tab and searches on the name and calls up the application and has the caller identify the address on the application, for verification purposes. The CSC goes to the Eligibility Determination screen and checks to see if there was a final determination made as of yet. The CSC can also see what correspondence was sent from the same screen and when it was sent	During the first 10 days after submitting the application	KID*Connect*
C.3	*hawk-i* applicant mother	The same caller would like to enroll the eligible children in health plan and know the premium amount needed to send.	During the first 10 days after submitting the application	-
C.4.a	System	Available Health Plan Choices. The available health plan choices are predetermined from the rules based logic built into the system, which is based on county/zip code information from the application.	After eligibility determination has been made	KID*Connect*
C.4.b	System	Premium Calculation. The premium owed is based	After eligibility	KID*Connect*

Step	Who	Does what	When	Application
		on a percentage of the the FPL from family countable income and the calculation of premium is determined with the eligibility determination.	determination has been made	
C.5	Customer Service Coordinator	The CSC checks the Financial view of KID*Connect* to see that the family has a zero dollar premium. The CSC moves to the Health Plan page and can view the available plans for the dependents. She selects the plan indicated by the mother.	During the first 10 days after submitting the application	KID*Connect*
C.6	System	The system prompts the CSC as to whether a letter confirming the health plan choice should be sent to the household. When the CSC selects "yes", a letter is populated with the applicant's address and health plan information and is automatically sent to the print queue. A copy of the dated letter is retained within KID*Connect*, which is labeled and accessible by the CSC from the case correspondence tab.	After A.7	KID*Connect*
C.7	System	Creates enrollment record(s) to be included on the 834 to the health plan and assigns the effective date of the enrollment as the first day of the next month.	After C.5 or after premium due is collected.	KID*Connect*
Mail room support				
C.8	Mail support clerk	Mail room support for: - Enrollment Packets - Coupon mailing	Daily	Scanner/Printer

D. Typical Customer Service Interaction with Enrollee

When an enrollee's parent contacts the ***hawk-i*** program regarding the status of the premium payment, the caller has the option to utilize the Automated Voice Response system to convey the unique identifier for the child (step **D.2**). The caller can opt to speak directly to the Customer Service Coordinator if the unique identifier is not known. When the caller enters the unique ID, the first available Customer Service Coordinator will be assigned the call and the demographic information will appear on the screen in the **KID***Connect* application. Otherwise, the first available CSC will need to call up the child's information using demographic information supplied by the caller. In step **D.3**, the CSC asks the caller to identify themselves and provide some additional information for verification purposes. The CSC then enters the Financial View of the system and retrieves the information for the caller. In steps **D.5**, the Customer Service Coordinator can further drill down into the ledger detail of PeopleSoft Financials via **KID***Connect* to retrieve the check detail information.

Step	Who	Does what	When	Application
Enrollee Inquiry				
D.1	*hawk-i* enrollee mother	Calls the *hawk-i* program to ensure receipt of her last payment payment.	Prior to day 20 of the month	-
D.2	System	The Automated Voice Response prompt the caller to enter her case number or unique *hawk-i* ID for the child. The caller can enter the number or enter zero to speak to a representative. By entering the unique ID, the call is routed to an available Customer Service Coordinator and the demographic information for the child appears in KID*Connect* for the Customer Service Coordinator.	After D.1	Toshiba Phone System and KID*Connect*
D.3	Customer Service Coordinator	The CSC greets the caller and has the caller identify the address on the application, for	After D.2	KID*Connect*

Step	Who	Does what	When	Application
		verification purposes. The CSC goes to the Financial View of KID*Connect* to verify if payment is still outstanding.		
D.4	*hawk-i* applicant mother	The caller would like to verify the check number received.	After D.3	-
D.5	Customer Service Coordinator	The CSC can drill down into the financial view which then calls up the ledger detail within PeopleSoft Financials to see the check number, and the date of the check.	After D.4	KID*Connect* And PeopleSoft

V. Monthly Enrollment Data

HMS will make raw enrollment data available to the Department on a monthly basis at no additional charge pursuant to section 3G.1.F of the RFP.

V. Best and Final Offer

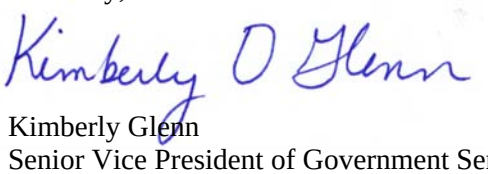
HMS also submits a Best and Final Offer, which provides the Department a reduction in our implementation, operations, change service rate, and per member per month pricing. Please see the attached revised Attachment 12 on page 16 that reflects these pricing changes.

VI. Summary and Conclusions

In summary, HMS is extremely excited about the opportunity to work with the Department in the administration of the Iowa ***hawk-i*** program. With the emphasis on SCHIP at a national level, along with Governor Culver's commitment to expand the ***hawk-i*** program through legislation such as HF2539, the Department must be confident in its choice of the next ***hawk-i*** administrative services vendor. HMS has demonstrated success in serving state government clients since 1974 and has an outstanding history of successful implementations and operational excellence.

HMS has been a trusted partner with the state of Iowa since 1990, and we have consistently provided the state with a qualified team, a reliable system, a solid project plan that generates results, and competitive pricing. As we have demonstrated with our proposal, HMS will once again meet and exceed the expectations of the Department as the ***hawk-i*** Third Party Administrator.

Sincerely,



Kimberly Glenn
Senior Vice President of Government Services

Attachment 12 -- Cost Proposal Form
NOT CONFIDENTIAL -- this form may not be designated as confidential in whole or in part.

	Contract Signing through 12/31/2008	Year 1 1/1/09 - 6/30/09	Year 2 7/1/09 - 6/30/10	Year 3 7/1/10 - 6/30/11	Option Year 4 7/1/11 - 6/30/12	Option Year 5 7/1/12 - 6/30/13	Option Year 6 7/1/13 - 6/30/14
Implementation Costs							
Mainframe Costs	$ -						
Office Computer Equip.	$ 195,725.36						
Software Licensing	$ 133,039.09						
Furniture	$ 97,855.70						
Leases for Office Space	$ 49,479.16						
Data Connectivity	$ 18,363.50						
Initial System Development	$ -						
Programming Costs	$ 15,504.00						
Salary and Benefits	$ 497,539.68						
Travel Expenses	$ 101,802.00						
Other	$ 27,989.85						
Operations Costs {yearly values only}							
Salary and Benefits		$ 628,404.00	$ 1,009,825.28	$ 1,072,532.11	$ 1,137,173.29	$ 1,204,904.21	$ 1,275,872.06
Audit		$ -	$ 40,039.27	$ 41,229.82	$ 42,454.66	$ 43,714.72	$ 45,010.99
Lease, Utilities, Connectivity		$ 81,045.44	$ 160,716.30	$ 162,781.36	$ 164,960.33	$ 167,258.15	$ 169,679.92
Other		$ 51,318.82	$ 55,441.05	$ 56,858.64	$ 64,599.95	$ 64,635.92	$ 53,946.72
Change Service Rate							
Average hourly rate for all Change Requests		$ 92.50	$ 92.50	$ 92.50	$ 102.50	$ 102.50	$ 102.50
Per Member Per Month Rate (To be used in the event that Contractor is entitled to an increase pursuant to Contract terms because of increase obligations)							
PMPM Value		$ -	$ 2.90	$ 3.01	$ 3.11	$ 3.22	$ 3.32

Subtotals							
Implementation Grand Total	$ 1,137,298.34						
Operations Grand Total	$ 7,794,402.99	$ 760,768.26	$ 1,266,021.90	$ 1,333,401.92	$ 1,409,188.23	$ 1,480,512.99	$ 1,544,509.69
Monthly Operations Average	$ 118,097.02	$ 126,794.71	$ 105,501.82	$ 111,116.83	$ 117,432.35	$ 123,376.08	$ 128,709.14
CSR Average	$ 97.50						
PMPM Average	$ 2.59						